Understanding the Concept of a `Good Death' in Japan: Views of First-year Medical Students

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Understanding the concept of a 'good death' in Japan: views of first-year medical students

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Previous studies have shown that conceptions of a 'good death' differ between patients, their families and medical staff, and even among medical staff. During end-stage cancer care, these differences may induce stress between patients, their families and medical staff. In the present study, we examined how first-year medical students (who had only received a very limited medical education) conceptualize a 'good death', and compared their views with those of medical staff and non-medical students. We found that the views of the first-year medical students differed from those of the non-medical students, but were similar to those of medical staff. This suggests that the professional identity of medical staff begins to form soon after admission to medical school.

Key words: good death, first-year medical student, palliative care, perception

Introduction

What is a 'good death' for advanced cancer patients? The answer to this question very much depends on whose point of view is being considered. Previous studies have identified differences in how patients, their families and medical staff conceptualize a 'good death'. Needless to say, all terminally ill cancer patients have a strong wish for a 'good death'. However, it is clearly difficult to ask cancer patients such questions as 'What is a 'good death' for you?' or 'How do you want to die?', and because of the sensitivity of this subject, there is little information available in the literature (Kendall, Harris, Boyd, Sheikh, Murray, Brown, Mallinson, Kearney, & Worth, 2007). In one study, the components of a 'good death' according to cancer patients were identified as being dying in one's sleep, dying quietly, dying with dignity, being pain free and dying suddenly (Payne, Langley-Evans, & Hillier, 1996). When it comes to conceptions of a 'good death', we generally tend to consider the views of a patient's family and medical carers as reasonable surrogates for the dying patient's view. In their study, Payne et al. found that a 'good death' for medical staff involved adequate symptom control, family involvement, peacefulness, and lack of distress. Of course, it is possible to argue that the very nature of death means that a good death is impossible. And some have stated that a 'good death' has yet to be realized (Aitini & Cetto, 2006). However, these arguments notwithstanding, a 'good death' is the

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ultimate goal for medical staff caring for patients with incurable cancer.

In previous studies, a wide range of components of a 'good death' have been identified. These can differ according to age, sex, disease stage, level of medical treatment, culture, religion and profession (Mak, 2001, Kikule, 2003, Grant, Murray, Grant, & Brown, 2003, Tsai, Wu, Chiu, Hu, & Chen, 2005). Despite the variation, there have been components that tend to be consistently identified by all those surveyed, for example, good pain control and dying with dignity. However, there are also components that tend to be desired by only one group of people. For example, patients tend to desire a sudden death, and medical staff tend to think it important that the patient has his or her family around at the time of death. Even among medical staff there are variations; doctors, palliative ward nurses and non-palliative ward nurses have been found to have different conceptions of a 'good death' (Murakawa & Nihei, 2009).

A question that arises out of this previous research is: How do medical students conceptualize a 'good death'? Ratanawongsa, Teherani and Hauer (2005) found that third-year medical students' experiences with dying patients during their first internal medicine clerkship affected their skills and attitudes in end-of-life care, as well as the emergence of their professional identities. Medical students such as these, who have had some experience in hospitals, may think about a 'good death' in practical terms. However, first-year medical students have generally had no experience with terminally ill patients, so their ideas are largely theoretical. In the present study, we investigated how first-year medical students conceptualize a 'good death' relative to the views of other groups. We used a questionnaire-based approach in which we asked first-year medical students, non-medical students, doctors, palliative ward nurses and non-palliative ward nurses to estimate what percentage of patients were able to achieve a particular component of a 'good death'. We used the components of a 'good death' that were identified in a previous Japanese study. That study involved semistructured interviews with advanced cancer patients, patients' families, physicians and nurses (Hirai, Miyashita, Morita, Sanjo, & Uchitomi, 2006).

Participants

All doctors and nurses working in the Miyagi Cancer Center, selected first-year medical students of Akita University, and selected first- to fourth-year non-medical students of Tohoku University were invited to participate in this study. A total of 29 medical doctors (14 physician and 15 surgeons), 13 palliative ward nurses, 122 non-palliative ward nurses, 30 first-year medical students and 31 non-medical students responded. The mean ages of these five groups were 45.0 (standard deviation [*SD*] 7.6), 36.9 (*SD* 7.2), 31.4 (*SD* 8.1), 19.4 (*SD* 1.5) and 21.3 years (*SD* 1.1 years), with response rates of 56.9%, 65.0%, 58.6%, 100% and 100%, respectively.

Methods

Of the 58 possible components of a 'good death' identified in our previous study (Hirai, Miyashita, Morita, Sanjo, & Uchitomi, 2006), we excluded seven components that, in our experience, doctors and nurses are not likely to contribute to in the contemporary Japanese

medical system (e.g. having no financial worries, having faith) and omitted components that were similar to or largely synonymous with others. The final list contained 28 components (Table 1). For each of the components, participants were asked "What percentage of patients do you think achieve this component necessary for a 'good death'?". Participants were asked to supply a figure between 0% and 100%. This value is hereafter referred to as the *achievement rating*.

In the nationwide quantitative study performed using the same components, the general population and bereaved family members were asked to rate the necessity (on a scale of 1-7) of each of the components of a 'good death' (Miyashita, Sanjo, Morita, Hirai, & Uchitomi, 2007). The percentage of ratings that were in the range 5-7 was taken as an index of the necessity of a component (hereafter referred to as the *necessity rating*). In the present study, we compared the achievement ratings with the necessity ratings for each of the five groups of personnel studied.

The ethics committee of Miyagi Cancer Center approved the methodology of this study.

Statistical analysis

Data were analyzed using Stat View-J5.0. Factor analysis (principal components analysis, varimax rotation) was employed to detect significant latent variables underlying a 'good death'. Factor loadings of $\geqq 0.5$ were considered for interpretation.

Results

For each of the 28 components of a 'good death', the achievement ratings assigned by the doctors, palliative ward nurses, non-palliative ward nurses, medical students and non-medical students were all lower than the necessity ratings assigned by the general population and bereaved family members.

For each of the 28 components of a 'good death', we compared the achievement ratings of the three medical staff groups and the two student groups using one-way ANOVA. For 14 components (including 'dying suddenly', 'not being connected to medical instruments or tubes', and 'being free from pain and physical distress'), there were significant differences among the five groups ($P < 0.05$). Of these 28 components, some are mutually exclusive, including 'dying suddenly' and 'having family by one's side when one is going to die', and also 'being free from pain and physical distress', 'not being connected to medical instruments or tubes' and 'being mentally clear'. Therefore, we examined these five components in detail (Figure 1). For all these five components, the achievement ratings of all five participant groups were lower than the necessity ratings given by the general population and bereaved family members. For 'dying suddenly', the achievement ratings of all participant groups were less than 30%. For 'having family by one's side when one is going to die', the achievement ratings of all participant groups were higher than 60%, and there was no clear distinction between the medical students and non-medical students. For 'being mentally clear', the achievement ratings of all participant groups were about 40%. In contrast, for 'being free from pain and physical distress' and 'not being connected to medical instruments or tubes', the achievement ratings of the student groups

were lower than those of the medical staff groups, with the non-medical students having the lowest rating, and the first-year medical students having a rating similar to those of the medical staff groups.

When the achievement rating data were interpreted using factor analysis, six factors, which explained 64.3% of the variance, were extracted (Table 2). Factor 1 consisted of four variables with high positive loadings on components concerning relationship with family and medical staff; this factor was termed 'good relationships' (contribution: 37.2%). Factor 2 consisted of five variables with high positive loadings on components relating to being free from physical and psychological pain and maintaining one's dignity: this factor was termed 'pain control and dignity' (6.8%). Factor 3 consisted of five variables with high positive loadings on components relating to sudden death and fight with the disease: this factor was termed 'sudden death and fight' (6.5%). Factor 4 consisted of three variables with high positive loadings on components relating to recognition of limited life-span and comfort: this factor was termed 'recognition of limited life-span' (5.0%). Factor 5 consisted of five variables with high positive loadings on components relating to expression of gratitude and preparedness for death: this factor was termed 'gratitude and preparedness for death' (4.7%). Factor 6 consisted of two variables with high positive loadings on components relating to satisfaction with treatment and respect for one's values: this factor was termed 'satisfaction and values' (4.1%). When the six factor scores were compared among the participant groups using one-way ANOVA (Table 3), four factors were identified as being mainly responsible for the differences between groups: 'pain control and dignity' ($F(4,191) = 16.989$, $P < .0001$), 'recognition of limited life-span' ($F(4,191) = 11.572$, $P < .0001$), 'gratitude and preparedness for death' ($F(4,191) = 2.56$, $P < .05$), and 'satisfaction and sense of values' ($F(4,191) = 3.643$, $P < .01$). Multiple comparisons analysis using the Tukey-Kramer method showed that the factor score of 'gratitude and preparedness for death' differed between first-year medical students and non-medical students (Figure 2). Non-medical students had higher factor scores than did doctors ($P < .05$) and first-year medical students tended to be similar to doctors.

Discussion

In this study, we investigated how first-year medical students, who have only a very limited medical education, conceptualize a 'good death', with reference to the views of medical staff, the general population and bereaved family members.

For all 28 components of a 'good death', the achievement ratings given by the medical and student groups were all lower than the necessity ratings assigned by the general population and bereaved family members. This result indicates that our respondents generally view delivering a 'good death' as a difficult undertaking. Interestingly, some components are mutually exclusive; for example, end-stage cancer can involve considerable pain, so patients require intensive treatment with narcotics to ensure that they are free from pain and physical distress. However, to deliver the drugs, patients must undergo intravenous intubation, thus precluding patients' wishes to be free of tubes and instruments. Furthermore, narcotics induce drowsiness in many cases, so

patients' wishes to be mentally clear are not achievable. Similarly, if patients die suddenly, they are unlikely to be able to have their family with them at the time of death. Despite these conflicts, almost 80% of the general population and bereaved family members think that the following five components are necessary for a 'good death': being mentally clear, dying suddenly, having family by one's side when one is going to die, not being connected to medical instruments or tubes, and being free from pain and physical distress. In other words, they want components that cannot be simultaneously realized. To tackle this problem, medical staff must attempt to explain when components are mutually exclusive. Without this understanding, conflicts may occur among medical staff, patients and their families in the final stages of cancer care.

Two components, 'not being connected to medical instruments or tubes' and 'being free from pain and physical distress', were both given significantly different achievement ratings by medical students and non-medical students. The medical students tended to think that these two components are more often achieved than did non-medical students. In this respect, the medical students had similar views to medical staff.

Our factor analysis showed a difference between medical students and non-medical students in the achievement scores for 'gratitude and preparedness for death'. This factor involves the mindset of patients and their families with respect to gratitude and preparedness for death. Non-medical students tended to consider that this factor is more often achieved than did doctors or medical students. One interpretation of this finding is that non-medical students have little contact with death, so given their strong desire for this factor to be realized, they believe it is often achieved in practice. In contrast, doctors know from experience that achieving the components of this factor is very difficult for dying patients and their families, so they rate it as being less achievable than did the non-medical students.

Although the first-year medical students in this study were freshmen, with very little medical education and little exposure to terminally ill patients, they displayed some similar views to doctors in their thinking about 'good death'. This suggests that the professional identity of medical staff begins to form soon after admission to medical school.

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